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BEFORE THE DEPARTMENT OF MANAGED
HEALTH CARE OF THE STATE OF CALIFORNIA

IN THE MATTER OF:	)	ENFORCEMENT MATTER 06-135
California Physicians' Service dba: Blue Shield of California	)	CONSENT AGREEMENT RE PAYMENT OF CLAIMS FOR EMERGENCY SERVICES AND CARE

I. RECITALS

THIS CONSENT AGREEMENT is entered into as of the 26th day of July, 2006, by and between California Physician Services dba: Blue Shield of California., a California non-profit corporation ("Blue Shield" or "Plan") and the CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE ("Department" or "DMHC").

Blue Shield is a full service health care service Plan ("Plan"), subject to the regulatory jurisdiction of the Department under the Knox-Keene Health Care Service Plan Act (Health and Safety Code sections 1340 et seq.) (the "Act").

On or about December 1, 2005, the Department commenced its investigation of complaints by certain health care service providers that Blue Shield was violating its claims payment obligations under the Knox-Keene Act by failing to directly reimburse non-contracted providers of emergency services and care rendered to Blue Shield PPO enrollees.

Blue Shield and the Department enter this Consent Agreement in order to reach a full and complete settlement of this issue and the Department's corresponding

Enforcement Matter 06-135. This Consent Agreement applies only to the Plan practice of paying PPO enrollees directly for certain provider claims involving emergency services and care.

II. FINDINGS AND ACKNOWLEDGEMENTS

The Department has found and, for the purposes of this Consent Agreement, Blue Shield acknowledges as follows:

A. The Knox-Keene Act and related regulations apply to the Plan and in pertinent part require the Plan to provide and/or pay for emergency services and care.

B. In December of 2005, certain emergency service and care providers submitted a claim payment complaint to the Department claiming that the Knox-Keene Act requires health plans to directly reimburse the provider for emergency services and care provided to PPO enrollees and that Blue Shield was improperly reimbursing its PPO enrollees, rather than the provider, for emergency care and services.

C. In late January 2006, the same emergency service and care providers complained to the Department that the Plan's form letter asserting that future payments to terminated providers would be made to Plan enrollees, rather than to providers, did not contain an exception for providers of emergency services and care.

D. In late January 2006, the Department contacted the Plan with regard to the complaints outlined in sections B. and C. above. The Plan immediately modified its form letter to terminated providers to include an exception to the Plan's direct payment policy with respect to claims for emergency services and care submitted by non-contracted providers.

E. Prior to the time the providers of emergency services and care contacted the Department regarding the complaints outlined in sections B. and C. above, the Plan had established a policy that, when paying claims from non-contracted providers for emergency services and care rendered to Plan enrollees, payment would be issued directly to the provider.

F. In the course of investigating the inquiry with the Department, the Plan determined that, notwithstanding its previously established policy, in some circumstances, the Plan was still issuing payments to PPO enrollees for services rendered by certain types of non-contracting providers who rendered emergency services and care. Upon this discovery, the Plan implemented certain interim administrative changes effective February 6, 2006, to attempt to direct all such payments to the non-contracting

physicians, pending the design and implementation of permanent systems modifications.

G. The Plan also notified the Department of its findings regarding payments being made to PPO enrollees for emergency services and care from non-contracting physicians and the corrective actions being initiated.

H. On March 17, 2006, the Department requested confirmation from the Plan that its interim corrective action was, in fact, resulting in the direct payment to non-contracting providers of emergency services and care. Upon investigation by the Plan, it became evident that the Plan's interim corrective actions had not been successful in that, in some instances, PPO enrollees were still receiving the payments that were due to non-contracted providers of emergency services and care.

I. The Plan subsequently identified why its earlier corrective actions were not successful, and implemented new and additional steps to reasonably ensure that payments due to non-contracted physician providers of emergency services and care are sent directly to those providers. In addition, the Plan voluntarily audited all claims for emergency services and care processed since February 6, 2006, where the payment was issued to the PPO enrollee rather than the non-contracting physician, and reissued payments directly to those physicians, including applicable interest.

III. CORRECTIVE ACTIONS TO BE COMPLETED AND/OR MAINTAINED BY BLUE SHIELD:

A. As of April 4, 2006, the Plan implemented the following interventions to reasonably ensure that payments due to non-contracted providers of emergency services and care are sent directly to the provider:

- Interim system changes were implemented to suspend automated processing of claims for non-contracting physician providers of emergency services and care. Further changes were implemented to ensure that claims processors issued payments to the providers.
- The Plan implemented a 100% audit of all such claims to ensure that the payments were issued to the providers.
- Additional training was conducted for all claims processors and audit staff. Moreover, specific focused training was conducted for all claims processors identified of the audit of claims incorrectly processed since February 6, 2006.
- Weekly reports of all claims paid for non-contracting physician providers of emergency services and care as well as all audit reports were generated for review by claims management.

As of June 16, 2006, the Plan completed the development, testing and implementation of permanent system enhancements. Under the newly implemented systems edits, the system will automatically adjudicate claims for emergency services and care from non-contracting physician providers and will automatically issue payment to the provider. Moreover, if there is any manual intervention in the claims process, either on initial adjudication or on appeal, the system will prevent the claim from being adjudicated or adjusted to issue payment to anyone other than the provider of emergency services and care. Testing of this change has confirmed that the system enhancement accomplishes the intended result.

B. The Plan has provided and will continue to provide necessary training of all claims processors and examiners to reasonably ensure that the claims payment process correctly identifies non-contracted providers of emergency services and care as the claim payee, and that the claim payment is in fact made to that payee.

C. The Plan has voluntarily audited all claims for emergency services and care processed since February 6, 2006, where the payment was issued to the PPO enrollee rather than the non-contracting physician, and has reissued payments directly to those physicians, including applicable interest, notwithstanding the fact that some of these providers may have been paid already by enrollees who had received payment from Blue Shield. The Plan did not seek to recover any of the payments made to PPO enrollees.

D. Regarding payments on claims for emergency services and care from non-contracting providers previously processed by the Plan, the Plan will audit all claims from non-contracted professional providers of emergency services and care that were processed between December 1, 2005 and February 6, 2006. The December 1, 2005 date was selected because this is the month the affected providers brought this issue to the Department's attention and in recognition that the affected providers did not avail themselves to the Plan's statutorily mandated provider dispute mechanism which would have provided the Plan with an early opportunity to address the issue. As part of this settlement agreement, for each claim that was not paid to the provider and instead was paid to the enrollee, the Plan will reprocess the claim and reissue payment, including all necessary interest, to the provider. This reprocessing shall occur without the need for a request from the affected provider. The Plan shall complete this re-processing and make all corrective payments by September 15, 2006.

E. For all claims reprocessed and paid by the Plan as described in subsection D. above, the Plan agrees that it will not recover any payments previously made directly to the enrollee.

F. By October 1, 2006, the Plan will submit to the Department a report that lists 1) the list of claims, by claim number, not directly paid to the provider, 2) the date of the original payment on the claim, 3) the amount paid upon reprocessing, 4) the amount of interest paid upon reprocessing and 5) the date the reprocessed amount was paid.

G. Regarding the letter to terminating PPO providers described in subsection II. C. above, the Plan modified the letter as of January 31, 2006, to clarify that it would not pay members directly for emergency services and care. The Department was immediately notified of this letter modification.

J. This Agreement is not a substitute for, nor is it intended in any way to bind or limit, any claims, appeals or related remedies otherwise available to providers whose claims were not paid correctly or denied as non-emergent.

IV. MITIGATING FACTORS

A. The Plan would like to see a forum available to both plans and providers to resolve claims payment disputes, short of litigation, arbitration or other expensive means of dispute resolution. In this regard, the Plan is in favor of an Independent Dispute Resolution Process that would be available to plans and non-contracting providers to resolve their disputes regarding claims payments. The Plan is aware that the Department is formulating a pilot program to develop such a process, the details of which are being determined with the assistance of all stakeholders. The Plan therefore would like to provide funding to the Department in the amount of $200,000 for start up costs for such a pilot program. The Plan will pay these funds to the Department within ten days of both parties signing this Consent Agreement.

B. If the start up costs do not exceed $200,000, the remaining portion of the funds provided by the Plan shall be used to offset the program's ongoing operational costs.

V. ADMINISTRATIVE PENALTY

A. In determining an appropriate penalty, the Department considers the sizable amount of funds provided to start a pilot program intended to assist providers and plans in resolving claims payment disputes to be a mitigating factor. Thus, the Department determines that an administrative penalty of $50,000 is warranted and justified in this matter. The Plan agrees to pay that penalty to the Department within ten days of both parties signing this Consent Agreement.

B. Blue Shield agrees that if it fails to timely complete the corrective actions agreed upon herein and/or otherwise materially breaches this Agreement, the Department is entitled to collect from Blue Shield an additional monetary penalty. In the event of such breach or further non-compliance, these terms of this Agreement also do not prevent the Department from exercising any and all other aspects of its disciplinary authority to ensure the Plan's compliance with all of its obligations.

IN WITNESS WHEREOF, the parties hereby execute this Consent Agreement by the signatures of their respective duly authorized officials.

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

Dated: Aug 4, 2006

By _____
Amy L. Dobberteen
Assistant Deputy Director and
Chief of Enforcement

CALIFORNIA PHYSICIANS' SERVICE
dba BLUE SHIELD OF CALIFORNIA

Dated: Aug. 3, 2006

By _____
Lyle S. Swallow, Esq.
Associate General Counsel